Board of Opticianry

Re-Examination Application

Department of Health
Florida Board of Opticianry
4052 Bald Cypress Way, #C-08
Tallahassee, FL 32399-3258
Telephone: (850) 245-4474
www.doh.state.fl.us/mqa/opticianry
Email: MQA_Opticianry@doh.state.fl.us

Rule 64B12-9.002, F.A.C.
Form DH-MQA 1190 (Revised 11/11)

Opticianry Re-Examination Application Instructions

Requirements for Re-Examination

- Completion of the Opticianry Re-Examination Application;
- Payment of $100.00 application fee, which is non-refundable; **and**
- Date of original failed examination is within two years of submitting the re-examination application.

The fee must accompany the application. Please make the check or money order payable to the Department of Health. Mail the application and fee to:

Board of Opticianry
P. O. BOX 6330
Tallahassee, FL 32314-6330

Exam Review Course: The Board of Opticianry does **not** offer an examination review course. Furthermore, there are **no** examination review courses that are endorsed by the Board of Opticianry.

Address Change: If your address changes, you must provide written notification to the board office. Include your full name, old address, new address, and whether this is your mailing and/or your practice location address.

Name Change: If you have a legal name change, you must provide signed, written notification to the board office. Include your full name as you applied, your new full name, and a photocopy of the applicable legal document. Your name cannot be changed without valid legal documentation.

Requirements For Licensure As An Optician

- Successful completion of all parts of the examination for Florida licensure;
- The original certificate documenting successful completion of a two-hour laws and rules course by a Board approved laws and rules course provider;
- Copy of certificate documenting successful completion of a two-hour continuing education course relating to the prevention of medical errors. The course must be approved by the Board and shall include a study of root-cause analysis, error reduction and prevention, and patient safety;
- Copy of certificate documenting successful completion of a two-hour live technical practice continuing education course on fitting and adjusting by a Board approved provider;
- No discovery of disqualifying factors prior to licensure;
- Payment of the initial licensure fee within one (1) year of notification of successful passage of the examination for Florida licensure; **and**
- Completion of Initial Licensure Form, see last page of this application packet.

All licensees are responsible for knowing the laws and rules that regulate their profession. The laws in Chapter 484, Part I, Florida Statutes (F.S.), are directly related to the profession of Opticianry, and Chapter 456, F.S., governs all health care professions licensed by the Department of Health. Rule Chapter 64B12, Florida Administrative Code (F.A.C.), are the rules that govern the profession of Opticianry. Rule Chapter 64B29, F.A.C., are the rules that govern optical establishments. The laws and rules are accessible at the Opticianry Website at www.doh.state.fl.us/mqa/opticianry.

COMPLETING THE APPLICATION

Original forms with an original signature must be submitted; photocopies will not be accepted. Print neatly in black ballpoint pen or type all information.

FLORIDA DEPARTMENT OF HEALTH

Opticianry Re-Examination Application (2001)

1. APPLICANT PROFILE DATA *(PLEASE TYPE OR PRINT IN BLACK INK)*

Name	Last	First	Middle
Mailing Address	No. and Street .		Apt. No.
	City	State	Zip Code
* Practice Location Address	No. and Street		Apt. No.
	City	State	Zip Code

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

Date of Birth: _____/_____/_____

Place of Birth: (City, State)

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name? ❑YES ❑NO If "YES", list name(s):

_____

Home Telephone: Area Code ( )	Business Telephone: Area Code ( )	Fax Number: Area Code ( )
E-Mail Address: (optional)		Sex: ❑ Male ❑ Female

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR 38295 (8/25/78). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure.

RACE: ❑ Caucasian ❑ African-American ❑ Hispanic ❑ Asian ❑ Native American ❑ Other _____

2. EXAMINATION HISTORY

List the date(s) of previous examination(s): Original Examination Date _____

Retake Date _____ Retake Date _____ Retake Date: _____

3. EXAMINATION PORTION(S) YOU ARE APPLYING TO RE-TAKE

❑ Spectacle Portion ❑ Contact Lens Portion

* Your Practice Location Address will show on our Internet License Verification, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address.

The practice location address must be a street address.

Tape one 2" x 2" photo here taken within the last six months.

Photo must be professional quality showing only the head and shoulders.

Print name on back of photo

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4. APPLICANT HISTORY – PROFESSIONAL

A.	Have you ever been denied licensure, certification, or registration for Opticianry or any health-related profession or the renewal thereof in any state?	❑ YES ❑ NO
B.	Have you ever been denied the right to take an Opticianry licensure examination?	❑ YES ❑ NO
C.	Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	❑ YES ❑ NO
D.	Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	❑ YES ❑ NO
E.	Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency?	❑ YES ❑ NO
F.	Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:	
	1. Acts of dishonesty, fraud, or deceit	1.❑YES ❑NO
	2. Lying on a resume or misrepresentation	2.❑YES ❑NO
	3. Academic misconduct, including acts such as cheating or plagiarism	3.❑YES ❑NO
	4. Theft	4.❑YES ❑NO
	5. Sexual harassment	5.❑YES ❑NO

If you answered "YES" to any question in Section 6, you must provide the board complete details.

5. APPLICANT HISTORY – GENERAL

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any crime in any jurisdiction, other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ❑ YES ❑ NO

If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You **must** include a certified copy of the court records/dispositions.

6. Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked**.**

If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

1a.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? **(<u>If no, do not answer 1b</u>.)**	❑ YES ❑ NO
1b.	Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?	❑ YES ❑ NO
2a.	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(<u>If no, do not answer 2b.</u>)**	❑ YES ❑ NO
2b.	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?	❑ YES ❑ NO
3a.	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? **(<u>If no, do not answer 3b and 3c</u>.)**	❑ YES ❑ NO
3b.	Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?	❑ YES ❑ NO
3c.	Did the termination occur at least 20 years prior to the date of this application?	❑ YES ❑ NO

7. APPLICANT STATEMENT

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by s. 456.072, F.S., and 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

The practice of Opticianry in Florida is governed by Chapters 456 and 484, Part I, Florida Statutes, and Chapter 64B12, Florida Administrative Code, which I state I have read and understand. I understand that it is my responsibility to keep informed of any changes to Chapters 456 and 484, Part I, F.S., and Chapter 64B12, Florida Administrative Code.

I understand that pursuant to s. 456.013(1)(a), F.S., an incomplete application shall expire 1 year after initial filing.

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

_____ _____

Applicant's Signature Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE *

Florida Department of Health

Board of Opticianry

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

Name: _____

Last **First** **Middle**

8. Social Security Number: _____

9. APPLICANT HISTORY – HEALTH

If you answer "YES" to any of the following questions, you must submit a current mental health status report from a licensed mental health professional, wherein this professional practitioner opines that you are able to practice with reasonable skill and safety to patients or clients.

A.	In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	❑ YES ❑ NO
B.	In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	❑ YES ❑ NO
C.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
D.	In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	❑ YES ❑ NO
E.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice your profession within the past 5 years?	❑ YES ❑ NO
F.	During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	❑ YES ❑ NO

Rule 64B12-9.002, F.A.C.
Form DH-MQA 1190 (Revised 11/11)

FLORIDA DEPARTMENT OF HEALTH

INITIAL LICENSURE FORM
OPTICIANRY (2001)

Do not write in this space.

Please Note: According to Rule 64B12-9.0015(5), Florida Administrative Code, the initial licensure fee **must** be paid within one year of notification of successful passage of the examination.

To receive your initial license, please complete and return this form with a check or money order made payable to the Department of Health for the initial licensure fee. The licensure biennium ends on December 31 of every even-numbered year. Please determine the correct amount of your initial licensure fee from the following information:

- If you submit the fee in an odd-numbered year, the initial licensure fee is $130.00 and you will be required to renew your license by December 31 of the following year.
  (Example: Submit $130 on 12/10/2011 and your first renewal will be 12/31/2012.)
- If you submit the fee between January 1 and August 30 of an even-numbered year, the initial licensure fee is $67.50 and you will be required to renew your license by December 31 of the same year.
  (Example: Submit $67.50 on 8/15/2012 and your first renewal will be 12/31/2012.)
- If you submit the fee after August 30 of an even-numbered year, the initial licensure fee is $130.00 and you will be required to renew your license by December 31 of the next even-numbered year.
  (Example: Submit $130 on 9/5/2012 and your first renewal will be 12/31/2014.)

  Note: The renewal cycle begins on September 1 of each even-numbered year and when a license is issued during the renewal cycle, the expiration date is for the following biennium.

NAME (PRINT NEATLY OR TYPE ALL INFORMATION) _____

LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER _____

MAILING ADDRESS _____

LOCATION ADDRESS _____

❑ CHECK THIS BOX IF YOUR MAILING OR LOCATION ADDRESS HAS CHANGED

Please return this form with a check or money order to:

Board of Opticianry
P.O. Box 6330
Tallahassee, Florida 32314-6330